	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL 01/26	ETED
		133100	B. WIN			01/20/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABIL	ITATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFECTIVE 1)		DATE
F0000							
F0000	Complaint IN00 IN00102884 and Complaint IN00 No deficiencies are cited. Complaint IN00 Federal/State de allegations are c Complaint IN00 No deficiencies are cited. Survey dates: Ja 2012 Facility number Provider numbe AIM number: 1	r: 155160 00289330 enny Marlatt, RN	F00	00			
	Census payor ty Medicare: 15 Medicaid: 52	pe:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

WLL011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155160	A. BUILDING	00	COMPLETED 01/26/2012
		100100	B. WING	ADDRESS CITY OF THE ZIP CORE	01/20/2012
NAME OF P	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE 16TH ST	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		CASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710	Other: 12	CESC IDENTIFY THYO HY ORGANITORY)	ing		DATE
	Total: 79				
	10.01. 79				
	Sample: 5				
	Supplemental Sa	ample: 4			
		es reflect State findings			
	cited in accordar	nce with 410 IAC 16.2.			
		completed 1/31/12			
	Cathy Emswiller	r RN			
			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WLL011

Facility ID: 000080

If continuation sheet Page 2 of 10

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E				ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155160	B. WIN			01/26/	2012	
VIII OF D				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				990 N 1	6TH ST			
STONEBROOKE REHABILITATION CENTRE & SUITES				NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE	
F0157	A facility must imn resident; consult w	nediately inform the						
SS=D		nown, notify the resident's						
		ve or an interested family						
		re is an accident involving						
		results in injury and has						
	the potential for re							
		nificant change in the						
	• •	l, mental, or psychosocial						
	or psychosocial st	rioration in health, mental,						
	threatening condit							
	•	need to alter treatment						
		a need to discontinue an						
	_	eatment due to adverse						
	•	to commence a new form						
		decision to transfer or						
		dent from the facility as						
	specified in §483.	12(a).						
	The facility must a	lso promptly notify the						
		own, the resident's legal						
		nterested family member						
		ange in room or roommate						
		ecified in §483.15(e)(2); or						
		ent rights under Federal or						
	•	ations as specified in						
	paragraph (b)(1)	or this section.						
	The facility must re	ecord and periodically						
		s and phone number of the						
	resident's legal rep	oresentative or interested						
ļ	family member.		Į .				ļ	
	Based on intervio	ew and record review, the	F01	57	F157		02/06/2012	
	facility failed to	ensure the						
	recommendation	s from the Registered			Notification of	ł		
		or gastric feeding and			_			
		re forwarded to the			changes			
		proval and signature						
		g the recommendations			\A/bat			
	prior to institutili	g me recommendations			What			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WLL011

Facility ID: 000080

If continuation sheet Page 3 of 10

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155160	B. WIN	G		01/26/	2012
NAME OF F	PROVIDER OR SUPPLIEI	₹	•		ADDRESS, CITY, STATE, ZIP CODE		
				16TH ST			
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG			DATE
	for 1 of 2 residents reviewed for gastric feeding tubes in a total sample of 5.				corrective		
	1	a total sample of 3.			action(s) will		
	(Resident #D)				action(s) will		
	Findings include	: :			be		
	D :1 . //D! 1				Accomplished for those residents Found to have bee	n	
		inical record was 4-12 at 8:27 a.m. His			affected by the Deficient		
		led, but were not limited			practice:		
	•	ar accident (CVA) with			Resident D's physician was notified of the Dietary	5	
		` '			recommendation and an orde	r is	
		ble CVA's with most to have occurred			now in place.	. 10	
					·		
		, diabetes, congestive			How will you ident	ify	
	`	IF), multi-infarct			other residents		
		agia, craniotomy as a			Having the potential to be		
		ral hematoma (bleeding			affected by the same deficie	nt	
	· · · · · · · · · · · · · · · · · · ·	April 2010 following heart			practice and what corrective		
	surgery, depress				action will be taken:		
	1 0	unostomy tube (GT-JT or			·All residents have the poter	ntial	
	feeding tube) an	d aphasia.			to be affected by the alleged deficient practice.		
		1			·The licensed nurses will be		
		lent #D's physician orders			re-educated by the DNS/desig	nee	
		cated a telephone order			(2/7/12)) on notification of a		
		gastric feeding fluids and			resident's physician for Dietar recommendations including	y	
	water flushes on				approval prior to documenting	in	
	-	ns.]" The telephone			the medication administration		
	orders did not sp	ecify what those			institution of the recommenda		
	recommendation	ns were. The RD had			Post test included.		
	specified the rec	ommendations in a			·Any other residents that		
	progress note, da	ated 1-17-12 at 12:09 p.m.			received dietary recommendations were review	_{ved}	
	The RD's recom	mendations indicated to			and orders received. If physic		
	continue the ente	eral feeding of Glucerna			does not agree with dietary		
		nula at 65 cc (cubic			_	ers	
		hour via the JT, but to				vill	
	continue the ento	eral feeding of Glucerna nula at 65 cc (cubic			_ · ·	ers	

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155160	B. WIN			01/26/2012
NAME OF F	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	C		990 N 1	16TH ST	
	STONEBROOKE REHABILITATION CENTRE & SUITES				ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	DATE
		r flushes of the tubing's to			be given to the DNS/designee the RD prior to RD exit day of	•
		after medication			visit.	
	administration v	ia the GT and an			·The director of nursing	
	additional 120 co	c of water every 4 hours			services/designee is responsil	ble
	via the GT. The	RD recommended to			to ensure compliance	
	flush the JT with	1 60 cc of water prior to			What measures will be put in	nto
		Glucerna feeding bottle via			place or what systemic	
		er flush recommendations			changes you will make to	
		an the previous water			ensure the deficient practice does not recur:	1
		_			• The licensed nurses will be	_
		evious orders, dated			re-educated by the DNS/desig	
		ed to provide 300 cc of			(2/7/12) on notification of a	,
	water every 6 ho	ours.			resident's Physician for Dietar	y
					recommendations including	
	These new recor	nmendations were			approval prior to documenting	
	indicated to have	e been documented on the			the medication administration	
	Medication Adm	ninistration Record			institution of the recommendate Post test included.	tion.
	(MAR) as specif	ried by the RD in the			·Dietary recommendations v	vill
		d were documented by			be given to the DNS/designee	
	ı ^ ~	as being conducted as			the RD prior to RD exit day of	
	_	RD's recommendations,			to obtain physician order.	
	effective on 1-17	· ·			·Every recommendation will	be
	effective off 1-17	7-12.			given to the DNS to ensure	_
		1 0 005			proper follow-up of physician's orders.	
		n the Staff Development			·The director of nursing	
		2 at 10:25 a.m., she			services/designee is responsil	ble
		d "found the current flush			to ensure compliance.	
	orders for the G-	tube and the J-tube on			·Non-compliance will result i	in
	the MAR, but no	p [physician] order for			further education including	
	itlooks like wh	oever did the MAR didn't			disciplinary action.	
	get the recomme	endations sent to the			How the corrective action(s) will be monitored to ensure t	
	~	She indicated the facility			deficient practice will not	iii G
		have the RD provide her			recur:	
	recommendation	•			·The CQI audit tool for Dieta	nry
					recommendations as well as	
		s would be faxed to the			change of condition will be util	
	physician for the	eir signature or would			daily x 4 weeks, bi-weekly x 2	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	DING	ONSTRUCTION 00	(X3) DATE (COMPL 01/26/	ETED	
		100100	B. WIN			01/26/	ZU 1Z
NAME OF I	PROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP CODE 6TH ST		
STONEE	BROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	have the physicing recommendation in the facility. So ensure a clarification forwarded to the the feeding and in RD's recommend. In interview with Services on 1-26 indicated the facts specific policy was accurate document. Records Directo 1-26-12 at 11:26 "Documentation revision date of indicated, "Purped document in an experiment."	an sign an order for the as when the physician was he indicated she would ation order would be physician in regard to flush orders, based on the dations. In the Director of Nursing 5-12 at 10:32 a.m., she ility does not have a which indicated "clear and entation." The Medical reprovided a policy on		TAG	months, monthly x 3 months a for 2 quarters thereafter for an resident who receives a dietar recommendation. Findings from the CQI proceivillate below 95%. Date of Compliance: 2/6/201	nd y y y ess an d	DATE
	medical record." This Federal tag IN00102884. 3.1-5(a)(3)	relates to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WLL011

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE COMPL	
AND FLAN	155160		A. BUII		00	01/26/	
		100100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				16TH ST		
	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362		
(X4) ID		MARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0514		naintain clinical records on	+	TAG	Dirichi.(CT)		DATE
SS=D	each resident in ac professional stand complete; accurate	ccordance with accepted lards and practices that are ely documented; readily estematically organized.					
	information to ider of the resident's as care and services preadmission scre State; and progres						
1		ew and record review, the	F05	14	F-514		02/06/2012
	facility failed to						
		s from the Registered			Records-comp)I	
	` ′	or gastric feeding and			ete/accurate/a	C	
		re forwarded to the				C	
		proval and signature			cessible		
	•	ating the recommendation					
		n administration record					
	_	e recommendations for 1 viewed for gastric feeding			What		
	tubes in a total sa #D)	ample of 5. (Resident			corrective		
	_π υ)				action(s) will		
	Findings include	:			be		
	diagnoses include to cerebrovascula history of multip recent indicated to December, 2011, heart failure (CH	4-12 at 8:27 a.m. His ed, but were not limited ar accident (CVA) with le CVA's with most to have occurred diabetes, congestive (F), multi-infarct			Accomplished for those residents Found to have been affected by the Deficient practice: Resident D's physician was notified of the Dietary recommendation and an order now in place. How will you identi	is	
	demenua, dyspna	agia, craniotomy as a					

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Event ID: WLL011

Facility ID: 000080

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED
		155160	A. BUII B. WIN			01/26/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8		l	16TH ST	
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES			ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	result of a subdu	ral hematoma (bleeding			other residents	
	in the brain) in A	April 2010 following heart			Having the potential to be	
	surgery, depress	ion,			affected by the same deficie	nt
	gastrostomy-Jeju	inostomy tube (GT-JT or			practice and what corrective	e e
	feeding tube) and	• `			action will be taken:	
					·All residents have the poter	ntial
	Review of Resid	ent #D's physician orders			to be affected by the alleged	
		cated a telephone order			deficient practice. The licensed nurses will be	
		•			re-educated by the DNS/design	
		gastric feeding fluids and			(2/7/12)) on notification of a	,
	water flushes on	, ,			resident's physician for Dietar	y
	-	ns.]" The telephone			recommendations including	
	orders did not sp	•			approval prior to documenting	
	recommendation	s were. The RD had			the medication administration institution of the recommenda	
	specified the rec	ommendations in a			Post test included.	uon.
	progress note, da	ated 1-17-12 at 12:09 p.m.			·Any other residents that	
	The RD's recom	mendations indicated to			received dietary	
	continue the ente	eral feeding of Glucerna			recommendations were review	
		nula at 65 cc (cubic			and orders received. If physic	cian
		hour via the JT, but to			does not agree with dietary	oro
		flushes of the tubing's to			recommendations dietary orde were obtained.	515
	_	after medication			·Dietary recommendations v	vill
					be given to the DNS/designee	
	administration v				the RD prior to RD exit day of	
		e of water every 4 hours			visit.	
		RD recommended to			·The director of nursing	hlo
		60 cc of water prior to			services/designee is responsi to ensure compliance	nie
	hanging a new C	Slucerna feeding bottle via			What measures will be put i	nto
	the JT. The water	er flush recommendations			place or what systemic	
	were different th	an the previous water			changes you will make to	
	flush orders. Pre	evious orders, dated			ensure the deficient practice	•
		ed to provide 300 cc of			does not recur:	
	water every 6 ho	•			· The licensed nurses will be	
					re-educated by the DNS/design	gnee
	These now room	nmendations were			(2/7/12) on notification of a resident's Physician for Dietar	v
		e been documented on the			recommendations including	'

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155160	B. WIN			01/26/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER			16TH ST	
STONEE	BROOKE REHABIL	LITATION CENTRE & SUITES			ASTLE, IN 47362	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Medication Adı	ministration Record			approval prior to documenting	
	(MAR) as speci	ified by the RD in the			the medication administration	
	progress note an	nd were documented by			institution of the recommendate Post test included.	uon.
	the nursing staf	f as being conducted as			·Dietary recommendations v	vill
	1	e RD's recommendations,			be given to the DNS/designee	
	effective on 1-1	-			the RD prior to RD exit day of	visit
		., 12.			to obtain physician order.	
	In intervious wi	th the Staff Development			·Every recommendation will	be
		12 at 10:25 a.m., she			given to the DNS to ensure proper follow-up of physician's	,
		,			orders.	'
		ad "found the current flush			·The director of nursing	
		I-tube and the J-tube on			services/designee is responsil	ole
		o [physician] order for			to ensure compliance.	
	itlooks like w	hoever did the MAR didn't			·Non-compliance will result i	n
	get the recomm	endations sent to the			further education including	
	doctor to sign."	She indicated the facility			disciplinary action. How the corrective action(s)	
	normally would	l have the RD provide her			will be monitored to ensure t	
	recommendatio	ns, then those			deficient practice will not	
	recommendatio	ns would be faxed to the			recur:	
	physician for th	eir signature or would			·The CQI audit tool for Dieta	ry
		ian sign an order for the			recommendations as well as	:
		ns when the physician was			change of condition will be util daily x 4 weeks, bi-weekly x 2	ized
		She indicated she would			months, monthly x 3 months a	ınd
		cation order would be			for 2 quarters thereafter for an	l l
					resident who receives a dietar	-
		e physician in regard to			recommendation.	
		flush orders, based on the			·Findings from the CQI proc	
	RD's recommer	idations.			will be reviewed monthly and a action plan will be implemente	
	.	4.4.5			for threshold below 95%.	~
		th the Director of Nursing			Date of Compliance: 2/6/201	2
		6-12 at 10:32 a.m., she				
		cility does not have a				
		which indicated "clear and				
	accurate docum	entation." The Medical				
	Records Directo	or provided a policy on				
	1-26-12 at 11:2					

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Event ID: WLL011

Facility ID: 000080

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155160	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED - 01/26/2012	
	PROVIDER OR SUPPLIER ROOKE REHABILITATION CENTRE & SUITES	990 N 1	ADDRESS, CITY, STATE, ZIP CO 16TH ST ASTLE, IN 47362	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION	ON
	"Documentation Guidelines," with a revision date of 2/2011. This policy indicated, "Purpose: To accurately document in an organized manner all information related to the resident in the medical record." This Federal tag relates to Complaint IN00102884. 3.1-50(a)(1) 3.1-50(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WLL011

Facility ID: 000080

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